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	085036	A. BUILDING _____ B. WING _____	C 05/13/2009

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FORWOOD MANOR	1912 MARSH ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual and complaint investigation survey was conducted at this facility from May 5, 2009 through May 13, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 66. The survey sample totaled 15 residents, which included a review of 13 active records and two (2) closed records.	F 000		
F 168 SS=B	483.10(g)(2) EXAMINATION OF SURVEY RESULTS A resident has the right to receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. This REQUIREMENT is not met as evidenced by: Based on a review of the Admission Packet, the facility failed to provide correct advocacy information to residents and family members. Findings include: A review of the Admission Packet on 5/7/2009 at 2:15 PM revealed that the telephone number of the State Certification Agency was incorrect in two areas. The areas were Information on How to File a Complaint with the State Certification Agency and the List of State and Local Advocacy Agencies.	F 168	F 168 1. No resident was identified by this deficient practice 2. All residents have the potential to be affected by the deficient practice 3. Corrected Admission Packets were re-issued to all residents with an attached Memorandum explaining the updated agency contact information. Previous forms with the incorrect telephone numbers have been discarded. 4. The admission director will make quarterly calls to the Delaware Helpline to obtain current telephone numbers. A quarterly audit of the admission packets for the correct telephone number will be completed. The audit will be presented to QI committee for review.	6/4/09
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator — 16 June 2009

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Administrator 16 June 09

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F 241	Continued From page 1 enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on review of investigative documents and interview, it was determined that the facility failed to promote care for 1 resident (R7) out of 15 sampled in a manner that maintained dignity. R7 was left naked sitting at the side of her bed for approximately 35 minutes on 3/8/09 while awaiting a gown. Findings include: R7 was admitted to the facility on 2/23/09 after quadricept repair surgery and debridement of her knee. She was morbidly obese. Review of R7's admission MDS (Minimum Data Set) assessment, dated 3/2/09, revealed that she was cognitively intact (independent in making consistent and reasonable decisions) without memory impairment. R7 was totally dependent on staff for dressing and she was non-ambulatory in her room. A complaint/grievance report form completed by the facility Social Service Director (E4) on 3/10/09, stated that R7 was assisted by staff with toileting on 3/8/09 at 7:10 PM, then she was "... put... on bed naked- 7:45 someone finally got her nightgown...". This was confirmed by the Assistant Director of Nursing (ADON-E3) on the grievance report: outcome/ resolution, dated 3/12/09, which further stated that the resident had requested a nightgown. Findings were confirmed with R7 during an interview on 5/5/09. R7 was able to easily recall	F 241	**F 241** 1. **R7** plan of care was revised on 3/11/09 to ensure care needs are met timely. The staff identified in the grievance report was provided an educational in-service on resident's rights and dignity on 3/24/09. **R7** remains in the facility and is currently satisfied with her care. 2. All residents have the potential to be affected by this cited practice. 3. All current and new CNA staff will be in serviced on Resident's Rights and providing care with dignity. 4. Weekly random customer satisfaction audits will be completed by the Social Services Director x 3 months to ensure that resident's rights are being maintained. Findings will be reported to the Administrator with immediate corrective action as warranted	7/12/09

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F 241	Continued From page 2 and relay the events of 3/8/09.	F 241		
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that the MDS (Minimum Data Set) assessments for 3 out of 15 sampled residents (R3, R7 and R9), failed to accurately reflect the residents' status. Findings include:	F 278	**F278** 1. Upon being informed of coding errors, a corrected MDS was immediately submitted reflecting **R9's** code status of Full Code as well as a physician order obtained for the correct code status. **R3's** MDS was corrected immediately and submitted to reflect diagnosis of URI. **R7's** MDS was immediately corrected and submitted to reflect falls within the last 30 days. 2. All resident's have the potential to be affected by this cited practice. 3. All current residents' MDS records will be audited to ensure correct coding of diagnosis, falls and code status. 4. Random Monthly Audits will be completed on resident's records to ensure accuracy of MDS by the DON/ Nurse Designee. Findings will be submitted to the administrator with immediate corrective action as warranted and will be reviewed at the QI meeting for compliance.	7/12/09

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F 278	Continued From page 3 1. R9 was admitted to the facility on 10/17/08 with diagnoses including dementia, urinary tract infections and chronic renal insufficiency. The quarterly MDS, dated 3/30/09, miscoded R9's code status as "do not resuscitate" (DNR). According to the 3/30/09 MDS, R9's cognitive skills for daily decision making were coded as, "moderately impaired - decisions poor", with short and long term memory problems. On 10/20/08, R9's spouse indicated that R9 was to be resuscitated (full code) and hospitalized. Review of the clinical record revealed that there was no physician's order for a DNR between 10/20/08 and 3/30/09. The facility failed to accurately assess R9's code status on the 3/30/09 MDS. On 5/8/09, findings were confirmed by E2, the Director of Nursing (DON) and post interview a physician's order was obtained to change the code status to full code and hospitalize for R9. Findings of the MDS miscoding were discussed at the informational meeting on 5/13/09. 2. R3 was admitted to the facility on 4/30/07 with diagnoses including stroke and difficulty swallowing. The quarterly MDS, dated 2/18/09, was miscoded for a "Urinary Tract Infection in the last 30 days". R3 had an upper respiratory infection (URI), not a urinary tract infection (UTI). The facility failed to accurately assess R3's status on the MDS. On 5/7/09, findings were confirmed with E5, the MDS Coordinator, who then completed an MDS correction.	F 278		

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F 278	Continued From page 4 3. R7 was admitted to the facility on 2/23/09. According to an undated hospital history and physical (admission date 2/10/09), R7 presented to the ER due to a fall that morning. While trying to stand, she fell and was unable to get back up. R7 subsequently underwent surgery for a quadricept tear and a knee debridement. The facility incorrectly coded R7 as having no falls in her admission MDS (Minimum Data Set) assessment, when she should have been coded for a fall in the last 30 days. Findings were confirmed with E1 (Nursing Home Administrator) on 5/7/09.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		

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F 279	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to develop care plans to meet residents' medical and nursing needs based on their comprehensive assessments for 2 (R9 and R12) out of 15 sampled residents. Findings include: The facility's Documentation Systems Guidelines Policy ... stated, "An interdisciplinary plan of care should be reviewed/updated at the time the weekly/monthly nursing summary is completed and: Skilled Resident: Every 2 weeks for the first quarter, then quarterly and when indicated...". 1. R9 was admitted to the facility on 10/17/09 with dementia, urinary retention due to BPH (enlarged prostate), urinary tract infection (UTI) and chronic renal insufficiency. On 10/30/09, R9 was readmitted from the hospital due to a UTI and on 11/7/09, he was diagnosed with C. Difficile (infection of the colon that occurs primarily after antibiotic usage). The facility failed to develop a care plan for infection control/contact precautions related to the C. Difficile infection. On 5/8/09, findings were confirmed by E2, the Director of Nursing (DON). 2. R12 was admitted to the facility on 11/7/09 with diagnoses including right leg blood clot, coronary artery disease and high blood pressure. R12's admission medications included heparin injections (to treat and prevent blood clots) and on 12/11/08, R12's physician ordered coumadin (an anticoagulant or blood thinner). The facility failed to develop a care plan for the potential for abnormal bleeding related to anticoagulant therapy. On 5/12/09, findings were	F 279	**F 279** 1. **R9's** current health status does not indicate a need for an infection control care plan at this time. **R9's** C. Difficile infection was resolved with no negative outcome prior to the survey date. Upon being informed by surveyor of the missed anticoagulant therapy care plan for **R12**, a care plan was immediately completed and added to **R12's** plan of care on 5/12/09. 2. All residents have the potential to be affected by this cited practice. 3. All current license staff will be provided re-education on documentation system guideline policy and the care planning process and need for interim care plan within 24 hrs of admission. Care plans will be reviewed in the daily clinical meeting whenever there is a reported change in any resident's condition or health status, and with new admissions and re-admissions to ensure resident's care needs are met. 4. Weekly Random Audits will be completed by the DON/ Nurse Designee to ensure that care plans have been initiated or revised to reflect resident's current needs x 3 months. Findings will be submitted to the administrator and reviewed in the QI meeting with corrective action as warranted.	7/12/09

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F 279	Continued From page 6 confirmed by E1, the Nursing Home Administrator, (NHA).	F 279		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being for 2 residents (R1 and R15) out of 15 sampled in accordance with the plan of care. The facility failed to have lab work drawn per physician orders for R1 and R15 on 4/6/09 and 1/30/09, respectively. The facility additionally failed to identify the missed lab order in their 24 hour chart check for R1, a system designed to double check that all physician orders are properly transcribed and executed. A 24 hour chart check was not available for R15. Findings include: 1. Physician admission orders for R1, dated 4/1/09, included the lab tests CBC (complete blood count) and chem-7 (includes electrolytes, glucose, and kidney function tests) to be done on Monday (4/6/09). A physician order, dated 4/8/09, stated, "CBC, chem-7 4/9 (was not done 4/6!)." Record review confirmed the missed labs on 4/6/09. The CBC	F 309	**F 309** 1. **R1's** CBC & Chem 7 was drawn on 4/9/09 with no negative outcome identified. **R15** had a BMP drawn on 2/6/09 with no negative outcome identified. Both residents remain in the facility with current and timely lab results in their medical records. 2. All residents have the potential to be affected by this cited practice. 3. All current resident charts will be audited to ensure labs are current and timely as per physician orders. All current license staff will be in-serviced on the lab ordering process and procedure for following up of lab orders. 4. Lab Book will be reviewed daily by the 11-7 Supervisor to ensure labs have been drawn timely. A Monthly audit will completed on resident's charts with ordered labs for each month by the DON/ Nurse Designee and findings will be submitted to the administrator and reviewed in the quarterly QI meeting to ensure compliance with corrective action plan as warranted.	7/12/09

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F 309	Continued From page 7 and chem-7 were done on 4/9/09. Findings were confirmed with E2 (Director of Nursing) during an interview on 5/7/09. 2. R15 was admitted to the facility on 1/27/09 with diagnoses including congestive heart failure, recent acute renal failure, ambulatory dysfunction and history of a stroke. On 1/29/09, R15's physician ordered a BMP (a blood test about current status of the kidneys, blood sugar, and electrolytes) for 1/30/09. The facility failed to follow the physician's order and have the blood test done on 1/30/09. On 2/6/09, the physician ordered a "stat (urgent) BMP", which was done. On 5/12/09, findings were confirmed by E1, the Nursing Home Administrator (NHA).	F 309		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329		

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F 329	Continued From page 8 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that 1 resident (R11) out of 15 residents' was free from unnecessary drugs. R11 was admitted to the facility with a known drug allergy to the antibiotic (ABT) Levaquin, which could cause adverse consequences if administered. Despite this, Levaquin was ordered for a URI (upper respiratory infection) on 3/22/09 and R11 received a dose. When R11's daughter was notified on 3/22/09, she requested that her mother not receive any more Levaquin until her reaction to the medicine could be clarified by the facility with the primary physician. On 3/23/09, a physician ordered the Levaquin to be discontinued and the ABT was changed to Zithromax. On 4/14/09 Levaquin was ordered again for a URI and R11 received another dose. The Levaquin was discontinued and R11 was started on Zithromax. Findings include: R11, a 97 year old female, was admitted to the facility on 2/23/09 with diagnoses including a gastrointestinal bleed from Coumadin (blood thinner) and congestive heart failure. Documents in the clinical record revealed the following allergies: face sheet- Levaquin, peanuts and Sulfas (ABT) admission physician order sheet (2/23/09)-	F 329	F 329 1. All of **R11's** noted allergies are currently transcribed correctly on the physician orders, medication administration record and pharmacy has an updated profile. **R11** remains in the facility with no negative outcome from the medication received on 3/22/09 and 4/14/09. 2. All residents have the potential to be affected by this cited practice. 3. All current resident's physician orders, and medication administration records will be reviewed for accuracy of identified allergies. All current license nurses will be provided an educational in-service on preventing transcription errors and the importance of checking allergies with new medication orders. 4. A weekly random audit of 10 % of the resident population will be completed until all current residents have been reviewed in order to ensure that each resident's allergies have been accurately transcribed to the physician order sheet and the medication administration record. Thereafter, random audits will be completed on a quarterly basis. Findings will be submitted to the administrator and reviewed in the quarterly QI meeting with corrective action as warranted.	7/12/09

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F 329	Continued From page 9 Levaquin, Tequin (ABT), Penicillin (PCN), Sulfa condition alert page- same as the admission order sheet admission nurse's note 2/23/09- Levaquin, Sulfa, PCN 3/09 MAR (medication administration record)- PCN, Sulfa While the facility failed to consistently list the same allergies in all areas of the record, it was clear that it was known that R11 was allergic to Levaquin from the day she was admitted to the facility. While the facility knew of the allergy, they failed to notify the pharmacy, so it would be added to the MAR and physician order sheet (POS). On 3/22/09, physician orders included, "Levaquin 500 mg po (by mouth) daily x 7 days" for URI symptoms. A NN(nurses note), dated 3/22/09, stated, "Received call Resident's daughter stating Resident is allergic to Levaquin. Does not remember what type of reaction Resident has... listed allergies are PCN & Sulfa (as per the MAR). Resident given 500 mg of Levaquin at 2:20 pm per Dr's order... 0 (no) s/s (signs and symptoms) of any adverse reactions... Daughter states staff to call Resident's primary physician in AM 3/23/09 (physician name and phone number given) and clarify what her allergies are... not to administer Levaquin until allergies are clarified... passed onto next shift...". A physician order was written on 3/23/09 to "D/C (discontinue) Levaquin, start Zithromax (ABT)...". A 3/23/09 nurse's note restated the above physician order and R11's daughter was notified of the change.	F 329		

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F 329	Continued From page 10 On 4/14/09, a physician ordered "Levaquin 500 mg po daily x 10 days" for URI symptoms. A 4/14/09 NN stated, "... Pt (patient) started on Levaquin this evening...". Review of the 4/09 MAR revealed that R11 received one dose of Levaquin. On 4/15/09, physician orders were written to discontinue the Levaquin and start Zithromax and "levaquin and Tequin allergy" was added to the orders. Levaquin and Tequin were handwritten onto the allergy section of the 4/09 MAR. Review of the 5/09 MAR, however, continued to only list allergies to PCN and Sulfa, but failed to include allergies to Levaquin and Tequin, despite being written onto the 4/15/09 physician orders. The facility failed to thoroughly transcribe all of R11's allergies from the admission physician orders and they failed to consistently list all of R11's allergies throughout the clinical record. As a result, they failed to recognize R11's allergy to Levaquin on 2 separate occasions when it was ordered by a physician and the medication was administered despite R11 being allergic to it. This administration had the potential for adverse consequences. The current 5/09 POS continued to exclude Levaquin and Tequin as allergies, despite 24 hour chart checks, a system designed to double check that all physician orders are properly transcribed and executed. Findings were reviewed and confirmed by E1 (Nursing Home Administrator) on 5/12/09.	F 329		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the	F 368		

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F 368	Continued From page 11 community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on group and individual interview, it was determined that the facility failed to routinely offer bedtime snacks to all residents. Findings include: 1. A group interview was conducted on 5/6/2009 at 1:30 PM with 10 participating residents (SSR16 through SSR25). During the meeting, all participating residents agreed that bedtime snacks were not being offered on a daily basis. According to Policy Number CL-NUR-1508, nourishments/snacks will be offered at bedtime (hs). 2. During an individual resident interview on 5/12/09 with R10, it was confirmed that evening snacks were not routinely offered to her at bedtime.	F 368	**F 368** 1. Identified residents will be followed up with to ensure HS Snacks are been offered on a consistent basis. 2. All residents have the potential to be affected by this cited practice. 3. All current CNAs will be in-serviced on the facility snack policy and procedure. A checklist will be developed to ensure HS snacks are offered to all residents and will be assigned daily for task completion. All CNAs will be in-service on the use of the checklist. 4. The 3-11 Shift Supervisor will daily review checklist to ensure all residents have been offered a snack. A monthly random audit will be done by the DON/Nurse Designee on 10% percent of the resident population to ensure compliance. Findings will be submitted to the administrator and reviewed in the QI meeting with corrective action as warranted.	7/12/09
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/28/
FORM APPRO
OMB NO. 0938-(

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085036	A. BUILDING _____ B. WING _____	C 05/13/2009

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F 428	Continued From page 12 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the pharmacist failed to identify and report an irregularity, specifically a drug allergy to the antibiotic Levaquin during the monthly drug regimen reviews for 1 (R11) out of 15 sampled residents. Consequently, R11 received Levaquin on 2 separate occasions in 3/09 and 4/09. Additionally, the pharmacy failed to update the 5/09 Physician Order Sheet (POS) after a physician order was written on 4/15/09 specifically stating that R11 was allergic to Levaquin. Findings include: The pharmacy policy entitled Drug Regimen Review (Monthly Report) stated, "... Findings and recommendations are reported to the administrator, director of nursing, the attending physician, and the medical director, where appropriate... DRR (drug regimen review) activities include but are not limited to... 1) Evaluating medication orders to determine that the resident's orders represent optimal therapy for that individual... c) Indications for use and therapeutic goals are consistent with current medical literature and clinical practice guidelines... 2c) Medical condition and response to drug therapy are used to evaluate the drug regimen for unnecessary medications."	F 428	**F428 cross ref. 329** 1. There were no negative outcomes for **R11.** 2. All residents have the potential to be affected by this cited practice. 3. The Consultant pharmacist will review all original admission orders for resident allergies and compare information to the MD order sheet, POS. The consultant pharmacist will document to the facility administrator and DON any inconsistencies found regarding allergies between the resident admission orders and the POS. The consultant pharmacist will note allergy with a check mark (✓) during the first drug regime of each resident each month. The consultant pharmacist will be provided additional training in the elements of chart review and drug regimen by the consultant Pharmacist's supervisor. 4. Monthly audits of 10% of resident charts will be conducted by the consultant pharmacist or designee until all current residents have been reviewed for documentation of allergy information in order to ensure compliance. Audit findings will be submitted to the administrator for review in the quarterly QI meeting. **Completion Date: July 12, 2009**	7/12/0

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F 428	Continued From page 13 cross refer F329 R11 was admitted to the facility on 2/23/09. Numerous areas of the clinical record stated that R11 was allergic to Levaquin, including the face sheet, condition alert page, and the admission physician orders. A DRR was done by a pharmacist on 2/25/09 and they failed to identify this allergy and therefore failed to present any potential adverse consequences. R11 received a dose of Levaquin on 3/22/09 for an upper respiratory infection (URI); the Levaquin was subsequently discontinued on 3/23/09. A DRR was done on 3/29/09 which stated, "... Levaquin x7 (days)... D/C (discontinue) Leva (Levaquin) start Zithro (Zithromax)...". R11 received another dose of Levaquin on 4/14/09 for an URI; the Levaquin was discontinued on 4/15/09. The 4/15/09 physician order included "Levaquin and Tequin (another antibiotic) allergy." A DRR was done by a pharmacist on 4/28/09. Review of the 5/09 medication administration record revealed that Levaquin and Tequin were not added to the list of allergies. Multiple monthly DRR's by the facility's contracting pharmacist were not thorough and the pharmacist failed to identify that R11 was allergic to Levaquin. Consequently, recommendations were not made to the facility notifying appropriate parties of the allergy and R11 incorrectly received Levaquin on two occasions. In addition, even after a physician order was written to notify the pharmacy that R11 was allergic to Levaquin and Tequin, the pharmacy failed to update the	F 428		

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F 428	Continued From page 14 Physician Order Sheet accordingly leaving the resident at risk to receive Levaquin again. Findings were reviewed and confirmed with E1 (Nursing Home Administrator) on 5/12/09.	F 428		
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to maintain clinical records on six (6) residents (R1, R7, R9, R10, R12, and R15) out of 15 sampled residents in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The facility additionally failed to follow their own policy regarding documentation of the influenza and pneumococcal vaccines. Findings include: According to the Resident Health Program, policy 3 CL-SNF-IC-3016, "Determine if resident has previously received the pneumococcal vaccine. Document information on the consent and the	F 514		

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F 514	Continued From page 15 Immunization record... Document the administration of the flu vaccination on the resident's immunization record." 1a. R1, a 97 year old female, was admitted to the facility on 4/1/09 with diagnoses including Meniere disease with deafness (inner ear disorder affecting hearing and balance), chronic pain, osteoporosis, depression and dementia. The admission fall risk assessment, dated 4/1/09, listed R1 as low risk for falls. Parameters used to calculate the total score included orthostatic checks (comparison of BP lying down then sitting or standing to check for changes). No BP's were written in the blanks, yet R1 was incorrectly assigned a "0" indicating she had no changes in her BP or pulse. R1 was assigned a score of "2" for medications that placed her at risk for falls; 1-2 meds. This was underscored as R1 was on 3 or > meds that placed her at risk; she should have received 4 points. The facility incorrectly scored R1 with "2" points for diagnoses/clinical concerns; 1-2 diagnoses. R1 should have been scored with 4 points for 3 or > diagnoses as she had 9 of the listed diagnoses. R1 would have been a moderate risk for falls according to the fall risk assessment if scored correctly. Findings were reviewed and confirmed with E2 (Director of Nursing) on 5/6/09. 1b. Review of R1's admission nurse's note, dated 4/1/09, stated, "... unsure if received flu or pneumonia vaccine will pass on to next shift to check c (with) family when they arrive."	F 514	**F 514** 1. **R 1** has expired. **R7's** immunization record has been updated to reflect current immunization status. **R15** was discharged to home. **R9's** DNR status was clarified; order was obtained for DNR and documented in the clinical record. **SSR18's** identified quarterly MDS assessment was properly placed in correct clinical record. **R10** had no order identified for magic cup. **R17's** order for the magic cup was documented correctly onto the physician order sheet. 2. All residents have the potential to be affected by this cited practice. 3. Professional staff will be in serviced on the medical record chart organization policy and the management of health records. License staff will be re-educated on the facility policy on Flu and Pneumovac immunizations and use of immunization record. Facility system for maintaining the accuracy of the residents clinical record will be reviewed and modified as needed. A weekly audit will be completed by the DON/Nurse Designee on new admissions to ensure the Flu and Pneumovac vaccine has been offered and consent signed. An immunization log will be maintained to keep account of all immunizations administered.	7/12/09

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F 514	Continued From page 16 Review of the admission MDS (Minimum Data Set) assessment, dated 4/8/09, indicated that R1 received the flu vaccine outside of the facility and stated that her pneumococcal vaccine was up to date. E5 (MDS Coordinator) was interviewed on 5/7/09 and she stated that she obtained the information from the assisted living area where the resident previously resided. Review of the Immunization Record, however, was blank for the influenza (flu) and pneumonia (pneumococcal) vaccines. The Resident Immunization Consent Form for these vaccines was also blank. Although E5 obtained flu and pneumococcal vaccine information for the MDS, the facility failed to have the information documented on the Immunization Record and to have a completed Resident Immunization Consent Form, which includes why the immunizations are to be given or not. 2. R7 was admitted to the facility on 2/23/09. Review of the Immunization Record for the flu and pneumococcal vaccines revealed a blank form, as was the Resident Immunization Consent Form. No immunization information was found in the nurse's notes. The admission MDS assessment, dated 3/2/09, however, indicated that R7 received the flu vaccine (failed to list reason flu vaccine was not administered in the facility, as it was received outside of the facility) and stated that her pneumococcal vaccine status was up to date. Findings were confirmed with E2 (Director of	F 514	4. A random of audit of the medical record will be completed monthly by the DON/Nurse Designee of 10% of the resident population to ensure accuracy of chart organization and compliance with immunizations. Findings will be reported to the administrator and reviewed in the QI meeting with corrective action as warranted.	

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F 514	Continued From page 17 Nursing/RNAC) on 5/7/09. E2 stated that R7 was able to supply her own immunization status information as the resident was cognitively intact. E2 stated that her practice was to write immunization information in a nurse's note, but she failed to do so. Post interview, the information was documented in all applicable areas. The facility failed to have R7's flu and pneumococcal vaccine information documented in her Immunization Record and to have a completed Resident Immunization Consent Form. 3. On 5/12/09, review of R15's clinical record revealed that there was no documentation to support that R15 had a pneumococcal vaccine as documented on the admission MDS, dated 2/3/09. The Immunization record was blank and there was no consent form on the record. Additionally, the initial physician orders and nurses notes were reviewed and lacked any documentation regarding whether the pneumococcal vaccine was up to date or not. The facility failed to have complete documentation regarding R15's pneumococcal vaccine status. On 5/12/09, findings were confirmed by E1, the Nursing Home Administrator and E8, the Regional Nurse. Cross refer F278, example #1 4a. There was a discrepancy in R9's code status on his record. The front sheet had a full code sticker, but written under it was, "3/23/09 DNR (Do Not Resuscitate) - RN may pronounce".	F 514		

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F 514	Continued From page 18 There was no physician order for a DNR in March 2009. Upon admission, the family signed that their choice was, "Resuscitate (Full Code), Hospitalize". The facility failed to have an accurately documented code status for R9. On 5/8/09, E2, the Director of Nursing (DON) confirmed the findings. 4b. On 5/6/09, review of R9's record revealed that the 1st page of the 5/09 POS (Physician's Order Sheet) was not on the record. The second page of the POS was signed by E7, a nurse, and noted that it was reviewed on 4/27/09. A monthly Drug Regimen Review/Pharmaceutical Care, dated 4/28/09, noted that the POS was not on R9's record to review. The facility failed to have a complete POS for May 2009 on R9's record. On 5/6/09, findings were confirmed by E2, the Director of Nursing (DON). The DON reported that R9's page 1 POS was located on another resident's record. 5. On 5/11/09, review of R12's clinical record revealed that a quarterly MDS, dated 2/15/09, of SSR18's was misfiled in R12's record. The facility failed to maintain R12's records accurately. On 5/11/09, findings were confirmed by E8, the Regional Nurse. 6. Review of R10's 5/09 POS (Physician Order Sheet) listed an order, dated 10/1/08 that stated, "Magic cup ice cream (supplement) BID (twice a day) c (with) meals." However, R10 was not admitted to the facility until 4/28/09.	F 514		

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F 514	Continued From page 19 On 5/12/09, during an interview with E6, a nurse, it was confirmed that this order was transcribed onto the wrong chart. E6 stated that R10 did not have an order for nor received this supplement but believed the resident's roommate, SSR17, received the "Magic cup." Review of SSR17's clinical record revealed documentation that confirmed that SSR17 received the "Magic cup" as ordered.	F 514		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Forwood Manor

DATE SURVEY COMPLETED: May 13, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State report incorporates by reference and also cites the findings specified in the Federal report. An unannounced annual and complaint investigation survey was conducted at this facility from May 5, 2009 through May 13, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 66. The survey sample totaled 15 residents, which included a review of 13 active records and two (2) closed records.	
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**	
3201	**General Services**	
3201. 6.1.1	**The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.**	

Provider's Signature Mary Ann King Title NHA Date 16 June 09

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	This regulation is not met as evidenced by: Cross refer to CMS 2567-L survey date completed 5/13/09, F309, F329, F368.	**Cross refer to CMS 2567-L POC for survey date completed 5/13/09, F309, F329, F368**	**7/12/09**
3201. 6.5	**Nursing Administration**		
3201. 6.5.5	**Based on the physician's admission orders and the admission information for each resident, an interim individual nursing care plan shall be developed within 24 hours of admission pending the completion of a comprehensive resident assessment.** **This regulation is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed 5/13/09, F279 Example 2.	**Cross refer to CMS 2567-L POC for survey date completed 5/13/09, F279, Example #2**	**7/12/09**
3201. 6.5.6	**A comprehensive care plan shall be developed to address medical, nursing, nutritional and psychosocial needs within 7 days of completion of the comprehensive assessment. Care plan development shall include the interdisciplinary team that includes the attending physician, an RN/LPN and other appropriate staff as determined by the resident's needs. With the resident's consent, the resident, the resident's family or the**		

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	resident's legal representative may attend care plan meetings. **This regulation is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed 5/13/09, F279 Example 1.	**Cross refer to CMS 2567-L POC for survey date completed 5/13/09, F279, Example #1**	**7/12/09**
3201. 6.5.7	**The assessment and care plan for each resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment.** **This regulation is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed 5/13/09, F278.	**Cross refer to CMS 2567-L POC for survey date completed 5/13/09, F278**	**7/12/09**
3201. 6.12	**Communicable Diseases**		
3201.6.12.2	**Specific Requirements for Tuberculosis**		
3201. 6.12.2.3	**All facilities shall have on file results of tuberculin tests performed on all newly admitted residents and newly hired employees,**		

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	and annually thereafter on all employees. A tuberculin test as specified, done within the twelve months prior to employment, or a chest x-ray showing no evidence of active tuberculosis shall satisfy this requirement for asymptomatic individuals. If an individual was previously documented as a positive reactor or has a history of hypersensitivity to the PPD test, a negative chest x-ray shall meet this requirement.	
3201.6.12.2.6	**Persons who do not have a significant reaction to the initial tuberculin test shall be retested within 7-21 days to identify those who demonstrate delayed reactions. Initial tests done within one year of a previous test need not be repeated in 7-21 days.**	
	This regulation is not met as evidenced by:	
	Based on record review and staff interviews, it was determined that the facility failed to retest and have on file results of the 2 step tuberculin tests performed on two residents (R7 and R15) out of 15 sampled residents. Findings include:	
	1. R15 was admitted to the facility on 1/27/09 and a step 1 PPD was administered on 1/27/09 and read on 1/30/09 with a negative result. The step 2	

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	PPD was administered on 2/6/09 but was not read by the facility. The facility failed to follow through to obtain the result of the step 2 PPD. On 5/12/09, findings were confirmed by E1, the Nursing Home Administrator and E8, the Regional Nurse. 2. R7 was admitted to the facility on 2/23/09 and a step 1 PPD was administered, which was negative. The facility failed to do the step 2 PPD. Findings were confirmed with E3 (Assistant Director of Nursing) on 5/7/09.	
3201.10.0	**Records and Reports**	
3201. 10.1	**There shall be a separate clinical record maintained on each resident as a chronological history of the resident's stay in the nursing facility. Each resident's record shall contain current and accurate information including the following:**	
3201. 10.1.1	**Admission record which shall include the resident's name, birth date, home address prior to entering the facility, identification numbers (including Social Security), date of admission, physician's name, address and telephone**	

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	number, admitting diagnoses, name, address and telephone number of resident's representative, the facility's medical record number, and advance directive(s) if applicable. **This regulation is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed 5/13/09, F514.	**Cross refer to CMS 2567-L POC for survey date completed 5/13/09, F514**	**7/12/09**
16 Del. C., Chapter 11, Subchapter II, § 1121	**Patient's Rights** **(1) Patient's Rights** **Every patient and resident shall have the right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality.** Cross refer to CMS 2567-L survey date completed 5/13/09, F241. **(23) Every patient and resident shall have the right to receive information from agencies acting as client advocates and be afforded the opportunity to contact those agencies.**	**Cross refer to CMS 2567-L POC for survey date completed 5/13/09, F241**	**7/12/09**

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16 Del. C., Chapter 11, Subchapter VII, § 1162	**This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed 5/13/09, F168 **Nursing Staffing** **(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement.** **Nursing staff must be distributed in order to meet the following minimum shift ratios:** **RN/LPN CNA*** **Day 1:15 1:8** **Evening 1:23 1:10** **Night 1:40 1:20** *** or RN, LPN, or NAIT serving as a CNA.**	**Cross refer to CMS 2567-L POC for survey date completed 5/13/09, F168** **6/4/09**

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STATE SURVEY REPORT

NAME OF FACILITY: Forwood Manor

DATE SURVEY COMPLETED: May 13, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Staffing for the period of 5 through 11 March 2009 was reviewed. The Daily Schedules and Payroll Hours per scheduled worker were checked. The citation below results from that work. **The law was not met as evidenced by:** Forwood failed to meet the Daily 3.28 Care Hours per Resident on ONE (1) date as shown below. The care hours per resident attained by the provider on that date are parenthesed. 1. Saturday, 7 March 2009 (3.24).	A system was implemented to ensure minimum staffing requirements are met on a daily basis. The day of the deficiency occurred on Daylight Savings time change. Going forward DST will be taken into account when the schedule is made.